

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2013
NAME OF PROVIDER OR SUPPLIER HOLSTON HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p>	F 272	<p>Credible allegation of compliance: F272</p> <ol style="list-style-type: none"> 1. Nursing staff have completed a side rail assessment for resident #78. 2. MDS has audited all patients' medical records for an assessment in the use of full side rails. 3. DON/ADON will complete in-service with nurses on the correct use of side rail assessments. Nurses will ensure assessments are completed. 4. MDS will audit patients with use of full side rails for an assessment & report results to QA monthly for the next 4 months. 	5/15/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

K. S. McCune

Administrator

April 25, 2013

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2013
NAME OF PROVIDER OR SUPPLIER HOLSTON HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, interview, manufacturers' recommendation review, and observation, the facility failed to accurately assess one resident (#78) for the use of side rails of thirty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #78 was admitted to the facility on October, 8, 2008, with diagnoses including Dementia, Alzheimer's Disease, Acute Encephalopathy, Hyperlipidemia, Arthritis, and Seizure Disorder.</p> <p>Medical record review of the Quarterly Minimum Data Set (MDS) dated January 10, 2013, revealed the resident was severely cognitively impaired and required extensive assistance with all activities of daily living (ADLs).</p> <p>Medical record review of the "ICF Weekly Nursing Summary" dated April 8, 2013, and March 10, 2013, revealed, "...dependent of mobility, transfer, and positioning..." Continued review of the "ICF Weekly Nursing Summary" dated January 28, 2013, revealed, "...lift with transfers, maximum assist with positioning..."</p> <p>Medical record review of the "Nursing Summary Report" dated January 11, 2013, revealed, "...S/R (side rail) up x2 (times two) for positioning..."</p> <p>Medical record review of the facility "Side Rail</p>	F 272			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2013
NAME OF PROVIDER OR SUPPLIER HOLSTON HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	<p>Continued From page 2</p> <p>Assessment" dated January 11, 2013, and April 8, 2013, revealed a star placed next to the following "...Patient uses side rails when in bed in order to perform bed mobility and pressure relief at modified independence. Patient should have BOTH (emphasis not added) side rails up to assist with bed mobility, but still allow freedom of movement..."</p> <p>Observation of the resident April 15, 2013, at 2:49 p.m., in the resident's room, revealed the resident laying in the bed with a full side rail on the right side of the bed in the up position. Continued observation of the resident, at that time, revealed the left side rail was in the down position.</p> <p>Observation and interview on April 15, 2013, at 3:09 p.m., in the resident's room, with Licensed Practical Nurse (LPN) # 1, confirmed the left side rail of the resident's bed was in the down position, and confirmed, "...should have both side rails up..." Continued interview with the LPN, at that time, revealed the resident was completely dependent for bed mobility, and the LPN stated the side rails were used for safety related to the resident's history of seizures.</p> <p>Interview on April 15, 2013, at 4:05 p.m., in the Private Dining Room, with the Director of Nursing (DON), and the Assistant Director of Nursing (ADON), confirmed the resident was completely dependent on bed mobility, and was unable to reposition independently "...the resident) ...unable to move on ... own ..." Continued interview with the DON and the ADON, at that time, revealed the use of side rails for the resident was not related to the resident's history of seizures, and confirmed the side rail</p>	F 272			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2013
NAME OF PROVIDER OR SUPPLIER HOLSTON HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 272	Continued From page 3	F 272			
F 282	assessments dated January and April 2013, did not accurately reflect the status of the resident for the use of side rails.				
SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	Credible allegation of compliance: F282	5/15/13	
	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.		1. Nursing staff have completed the "Behavior/Intervention Monthly Flow Record" as Care Planned for resident #49.		
	This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to follow a resident's plan of care for behavior monitoring of one resident (#49) of thirty-four residents reviewed.		2. Consultant Pharmacist will audit all patients with Psychoactive medication order to ensure "Behavior/Intervention Monthly Flow Record" are being filled out as Care Planned.		
	The findings included:		3. DON/ADON will complete in- service with nurses on accurate and timely documentation of "Behavior/Intervention Monthly Flow Record". Nurses will fill out the "Behavior/Intervention Monthly Flow Record" as Care Planned.		
	Resident # 49 was admitted to the facility on March 8, 2013, with diagnoses including Hypertension, Arthritis, Osteoporosis, Depressive Psychosis, Dementia, Alzheimer's Disease, and Behavior Disorder.		4. Consultant Pharmacist will monitor monthly and report results to monthly QA committee for the next 4 months.		
	Medical record review of the Admission Minimum Data Set (MDS) revealed the resident was severely cognitively impaired, and required extensive assistance with all activities of daily living (ADLs).				
	Medical record review of the resident's Medication Administration Record (MAR) for the month of April 2013, revealed the resident was prescribed Quetiapine (an antipsychotic medication) 100 milligrams (mg) at bedtime, and				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2013
NAME OF PROVIDER OR SUPPLIER HOLSTON HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page 4 Olanzapine (an antipsychotic medication) 5 mg every 6 hours as needed for "...agitation..." Medical record review of the resident's care plan dated March 26, 2013, revealed, "...Psychoactive medication usage for dx (diagnosis) of Behavior D/O (disorder)..." Continued review of the resident's care plan revealed, "...Monitor behavior on behavior monitoring sheet..." Medical record review of the resident's MAR for the month of April 2013, revealed a "Behavior/Intervention Monthly Flow Record" dated April 2013. Continued review of the "Behavior/Intervention Monthly Flow Record" revealed the record had medications documented, "...Quetiapine (an antipsychotic medication)" and "...Olanzapine (an antipsychotic medication)..." Further review of the "Behavior/Intervention Monthly Flow Record", at that time, revealed the rest of the form was blank. Interview with the Director of Nursing (DON) on April 16, 2013, at 8:50 a.m., in the Private Dining Room, confirmed the "Behavior/Intervention Monthly Flow Record" was prepopulated from the pharmacy with the medications that behavior monitoring was required. Continued interview with the DON, at that time, confirmed nursing staff were responsible for filling out the rest of the flow record for targeted behaviors that needed to be monitored. Further interview with the DON, at that time, confirmed the behavior monitoring flow record for the month of April 2013, was blank and the facility failed to follow the resident's plan of care for behavior monitoring.	F 282			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	Credible allegation of Compliance: F441		5/15/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2013
NAME OF PROVIDER OR SUPPLIER HOLSTON HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 5</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<ol style="list-style-type: none"> DON has educated said Aides and LPNs on the deficient practices. All nursing personnel have been educated on the importance of hand hygiene between patients and not holding the beverage containers and desserts by the rim. The Licensed Nurses have been educated on hand washing and/or sanitizing hands between patients during a Med pass. RD, CDM, DON, ADON, and Infection control nurse have observed meal & Med passes. No residents have been identified as having been affected by the practice listed. Nursing Administration will perform in-services to educate C.N.A. (s) & L.P.N.(s) of the stated deficient practices and the proper way to complete their meal & Med passes. RD, CDM, DON, ADON, and Infection Control Nurse will complete weekly audits of meal passes and Med passes to ensure that the deficient practice is not reoccurring. DON and/or Infection Control Nurse will complete studies and report results to QA committee for the next 4 months. 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2013
NAME OF PROVIDER OR SUPPLIER HOLSTON HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to follow infection control standards during a medication pass; and failed to maintain a sanitary environment to prevent the spread of infection during the residents mid-day main dining room meal service, and during the morning meal tray pass on one hall (600) of two halls observed.</p> <p>Findings Included:</p> <p>Observation of Licensed Practical Nurse (LPN) # 2 on April 14, 2013, at 9:27 a.m., in the 400 Hallway, revealed the LPN preparing and administering medications to the resident in room 401. Further observation revealed the LPN did not wash or sanitize the hands after administration of the resident's medication.</p> <p>Observation on April 14, 2013, at 9:35 a.m., in the 400 Hallway, revealed LPN #2 began to prepare medications for the resident in room 405 after leaving room 401. Further observation revealed LPN #2 administered the medications to the resident in room 405, exited the room, and began to prepare medications for the next resident without washing or sanitizing the hands.</p> <p>Interview with LPN # 2 on April 14, 2013, at 9:42 a.m., in the 400 Hallway, confirmed the LPN failed to wash or sanitize hands between residents during a medication pass.</p> <p>Observation on April 14, 2013, beginning at 12:40 p.m., in the main dining room revealed the following:</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2013
NAME OF PROVIDER OR SUPPLIER HOLSTON HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 7</p> <p>Certified Nurse Aide (CNA) #3 and CNA #4 were delivering meal trays and assisting residents by opening containers, cutting meat, buttering bread and positioning food/beverage items or utensils on the table for residents without sanitizing hands between residents.</p> <p>CNA #3 after the meal tray distribution and assisting residents, and without sanitizing hands, proceeded to feed one resident.</p> <p>CNA #4 came out of the dish room, walked past a sanitizer station, and sat down between two residents. Further observation revealed the CNA's hand was in physical contact with one of the resident's chin and throat. Further observation revealed the CNA had not sanitized hands after the physical contact and proceeded to assist and feed two residents simultaneously. Further observation revealed the CNA touched the top rim of the ice tea glass when assisting one resident to drink. Further observation of the CNA revealed the CNA opened the puree slaw and touched the rim of the slaw container prior to feeding a resident. Further observation revealed the CNA relocated the chair the CNA was using, went to a third resident, removed the resident's clothing protector, obtained and attached the arm rest onto the resident's wheel chair. The CNA failed to sanitize hands after contact with the third resident and went to the resident who was provided feeding assistance and removed this resident from the dining room. Further observation of the CNA returning to the dining room at 1:06 p.m., revealed the CNA was removing the lids from the dessert containers and touching the rim of each dessert container as the CNA was distributing the dessert to the residents.</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2013
NAME OF PROVIDER OR SUPPLIER HOLSTON HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3916 BOYD8 BRIDGE PIKE KNOXVILLE, TN 37914		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 8</p> <p>Interview with CNA #3 in the main dining room, on April 14, 2013, at 12:45 p.m., confirmed the CNA had not sanitized hands between residents when distributing and assisting residents with meal set-up and had not sanitized hands prior to feeding a resident.</p> <p>Interview with the Director of Nursing on April 14, 2013, at 1:15 p.m., in the Private Dining Room, confirmed the CNA's were to sanitize hands between resident contact.</p> <p>Observation of morning meal tray pass on April 15, 2013 at 8:05 a.m., on the 600 hall revealed CNA #1 entered room 601 with a meal tray then opened containers and gave the eating utensils to the resident. Further observation revealed the CNA exited room 601 then went to the cart with meal trays on it and removed a tray and entered room 602. Further observation revealed CNA #1 moved items from the resident's bedside table and placed the meal tray on the table. The CNA opened containers and gave the resident eating utensils. Further observation revealed the CNA repeated the process in room 603. CNA #1 did not wash or sanitize hands between resident rooms while delivering breakfast trays.</p> <p>Interview with CNA #1 on April 15, 2013, at 8:20 a.m., in the 600 hallway, confirmed the CNA failed to sanitize hands between resident rooms to maintain a sanitary environment.</p>	F 441			